		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038273

Facility Name: HERITAGE MANOR-MOUNT STERLING

Address: CAMDEN ROAD (Number) MT. STERLING (City) 61701 (Zip Code)

County: BROWN

Telephone Number: (217) 773-3377 **Fax #** ( )

IDPA ID Number: 370909086009

Date of Initial License for Current Owners: 07/01/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name CRAIG L. ATER **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) CRAIG L. ATER
(Title) SENIOR V.P. FINANCE

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	87	Skilled (SNF)	87	31,755	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	87	TOTALS	87	31,755	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,298	7,730	2,274	25,302	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	15,298	7,730	2,274	25,302	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 79.68%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? _____

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1985

J. Was the facility purchased or leased after January 1, 1978?
YES [xx] Date 1985 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 2,274

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Print Preview

	G/L	RECAP CENSUS	DIFF
PP	8688	8688	0
IPA	15346	15346	0
medicare	2274	2274	0
	26308	26308	

IPA BEDHOLDS	48
PP BEDHOLDS	40
PP CONVERS	918

Facility Name & ID Number HERITAGE MANOR-MOUNT STERL # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	130,030	10,991	0	141,021		141,021	2,689	143,710			1
2	Food Purchase		102,786		102,786		102,786	(521)	102,265			2
3	Housekeeping	68,436	11,945		80,381		80,381	0	80,381			3
4	Laundry	27,422	9,035		36,457		36,457	0	36,457			4
5	Heat and Other Utilities			77,125	77,125		77,125	1,095	78,220			5
6	Maintenance	20,982	24,357	18,523	63,862		63,862	8,626	72,488			6
7	Other (specify):*							0				7
8	TOTAL General Services	246,870	159,114	95,648	501,632		501,632	11,889	513,521			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400	0	2,400			9
10	Nursing and Medical Records	807,511	43,083	3,708	854,302		854,302	0	854,302			10
10a	Therapy		134,764	46,118	180,882	(298,386)	(117,504)	151,977	34,473			10a
11	Activities	25,663	1,395	0	27,058		27,058	0	27,058			11
12	Social Services	18,538	0	2,249	20,787		20,787	0	20,787			12
13	Nurse Aide Training	853	1,085		1,938		1,938	1,608	3,546			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16		852,565	180,327	54,475	1,087,367	(298,386)	788,981	153,585	942,566			16
	C. General Administration											
17	Administrative	43,384			43,384		43,384	23,837	67,221			17
18	Directors Fees							3,733	3,733			18
19	Professional Services			165,437	165,437		165,437	(152,689)	12,748			19
20	Dues, Fees, Subscriptions & Promotions			62,829	62,829	(45,443)	17,386	(5,530)	11,856			20
21	Clerical & General Office Expense	69,344	8,832	15,138	93,314		93,314	129,431	222,745			21
22	Employee Benefits & Payroll Taxes			160,336	160,336		160,336	18,372	178,708			22
23	Inservice Training & Education			460	460		460	705	1,165			23
24	Travel and Seminar			6,449	6,449		6,449	(4,450)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			19,533	19,533		19,533	1,322	20,855			26
27	Other (specify):*			13,300	13,300		13,300	(13,047)	253			27
28	TOTAL General Administration	112,728	8,832	443,482	565,042	(45,443)	519,599	1,684	521,283			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,212,163	348,273	593,605	2,154,041	(343,829)	1,810,212	167,158	1,977,370			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

Facility Name & ID Number HERITAGE MANOR-MOUNT STERL # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			109,819	109,819		109,819	4,029	113,848			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			97,524	97,524		97,524	(74)	97,450			32
33	Real Estate Taxes			38,338	38,338		38,338	0	38,338			33
34	Rent-Facility & Grounds							6,180	6,180			34
35	Rent-Equipment & Vehicles			1,906	1,906		1,906	12,258	14,164			35
36	Other (specify):*							0				36
37	TOTAL Ownership			247,587	247,587		247,587	22,393	269,980			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					298,386	298,386	0	298,386			39
40	Barber and Beauty Shops	0	0	0				0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					45,443	45,443	0	45,443			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers					343,829	343,829		343,829			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,212,163	348,273	841,192	2,401,628	0	2,401,628	189,551	2,591,179			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(649)	35		5
6	Rented Facility Space	0	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,769)	30		9
10	Interest and Other Investment Income	0	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(521)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	0	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(418)	20		17
18	Fines and Penalties				18
19	Entertainment	(9,461)	24		19
20	Contributions	(550)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(426)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,497)	27		24
25	Fund Raising, Advertising and Promotional	(8,630)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	0	23		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,921)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	224,472		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 224,472		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 189,551		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS **Page 5A**

Facility Name HERITAGE MANOR-MOUNT STERLING

IDH 0038272

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(182)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	0	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	(649)	35	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0		**Line 7**	0
8	**Laundry for Non-Patients**	0		**Line 8**	(182)
9	**Non-Straightline Depreciation**	(1,769)	30	**Line 9**	0
10	**Interest and Other Investment Income**	0	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0		**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0		**Line 11**	0
13	**Sales Tax**	(521)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	33	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	24	**Line 15**	0
17	**Non-Care Related Fees**	(418)	20	**Line 16**	0
18	**Fines and Penalties**	0		**Line 17**	0
19	**Entertainment**	(9,461)	24	**Line 18**	0
20	**Contributions**	(508)	27	**Line 19**	(426)
21	**Owner or Key-Man Insurance**	0		**Line 20**	(9,046)
22	**Special Legal Fees & Legal Retainers**	(426)	19	**Line 21**	0
23	**Malpractice Insurance for Individuals**	0		**Line 22**	0
24	**Bad Debt**	(12,497)	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(8,630)	20	**Line 24**	(9,401)
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	23	**Line 26**	0
28	**Yellow Page Advertising**	0	0	**Line 27**	(13,027)
29	**Non-Paid Workers**	0	0	**Line 28**	(31,595)
30	**Donated Goods**	0	0	**Line 29**	(32,340)
31	**Amortization Expense**	0	0	**Line 30**	(1,769)
32				**Line 31**	0
33				**Line 32**	0
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	(649)
37				**Line 36**	0
38				**Line 37**	(2,441)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
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Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	2,689	0	0	0	0	0	0	0	0	2,689	1
2	Food Purchase	(521)	0	0	0	0	0	0	0	0	0	0	(521)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,095	0	0	0	0	0	0	0	0	1,095	5
6	Maintenance	0	0	8,626	0	0	0	0	0	0	0	0	8,626	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(521)	0	12,410	0	0	0	0	0	0	0	0	11,889	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(2,448)		0	154,425	0	0	0	0	0	0	151,977	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,608	0	0	0	0	0	0	0	0	1,608	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	(2,448)	1,608	0	154,425	0	0	0	0	0	0	153,585	16
	C. General Administration													
17	Administrative	0	0	23,837	0	0	0	0	0	0	0	0	23,837	17
18	Directors Fees	0	0	3,733	0	0	0	0	0	0	0	0	3,733	18
19	Professional Services	(426)	0	9,153	0	(161,416)	0	0	0	0	0	0	(152,689)	19
20	Fees, Subscriptions & Promotions	(9,048)	0	3,518	0	0	0	0	0	0	0	0	(5,530)	20
21	Clerical & General Office Expenses	0	0	129,431	0	0	0	0	0	0	0	0	129,431	21
22	Employee Benefits & Payroll Taxes	0	0	18,372	0	0	0	0	0	0	0	0	18,372	22
23	Inservice Training & Education	0	0	705	0	0	0	0	0	0	0	0	705	23
24	Travel and Seminar	(9,461)	0	5,011	0	0	0	0	0	0	0	0	(4,450)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,322	0	0	0	0	0	0	0	0	1,322	26
27	Other (specify):*	(13,047)	0	0	0	0	0	0	0	0	0	0	(13,047)	27
28	**TOTAL General Administration**	(31,982)	0	195,082	0	(161,416)	0	0	0	0	0	0	1,684	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,503)	(2,448)	209,100	0	(6,991)	0	0	0	0	0	0	167,158	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(1,769)	0	0	5,798	0	0	0	0	0	0	0	4,029	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	(74)	0	0	0	0	0	0	0	(74)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	6,180	0	0	0	0	0	0	0	6,180	34
35	Rent-Equipment & Vehicles	(649)	0	0	12,907	0	0	0	0	0	0	0	12,258	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,418)	0	0	24,811	0	0	0	0	0	0	0	22,393	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(34,921)	(2,448)	209,100	24,811	(6,991)	0	0	0	0	0	0	189,551	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-MOUNT STERLING # 0028273 Report Period Beginning 01/01/01 Ending 12/31/01

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES - 6A

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V							1
2	V	10a Adjustment for Related Organizati	33,768	Greentree Therapy	100.000%	31,320	(2,448)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 33,768			$ 31,320	$ * (2,448)	14

Sum_6

-2448

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 2,689	$ 2,689	15	2689
16	V	2	Food Purchase				0		16	
17	V	3	Housekeeping				0		17	
18	V	4	Laundry				0		18	
19	V	5	Heat & Other Utilities				1,095	1,095	19	1095
20	V	6	Maintenance				8,626	8,626	20	8626
21	V	7	Other				0		21	
22	V	9	Medical Director				0		22	
23	V	10	Nursing & Medical Records				0		23	
24	V	11	Activities				0		24	
25	V	12	Social Service				0		25	
26	V	13	Nurse Aide Training				1,608	1,608	26	1608
27	V	14	Program Transportatior				0		27	
28	V	15	Other				0		28	
29	V	17	Administrative				23,837	23,837	29	23837
30	V	18	Directors Fees				3,733	3,733	30	3733
31	V	19	Professional Services				9,153	9,153	31	9153
32	V	20	Fees, Subscription, Promotions				3,518	3,518	32	3518
33	V	21	Clerical & General Office Expenses				129,431	129,431	33	129431
34	V	22	Employee Benefits & Payroll Taxes				18,372	18,372	34	18372
35	V	23	Inservice Training & Education				705	705	35	705
36	V	24	Travel and Seminar				5,011	5,011	36	5011
37	V	25	Other Admin. Staff Transportatior				0		37	
38	V	26	Insurance-Prop.Liab.Malpract				1,322	1,322	38	1322
39	Total			$			$ 209,100	$ * 209,100	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

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Print Page 6B

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		Sum_6B
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V		27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15	
16	V		30	Depreciation				5,798	5,798	16	5798
17	V		31	Amortization of Pre-Op & Org				0		17	
18	V		32	Interest				(74)	(74)	18	-74
19	V		33	Real Estate Taxes				0		19	
20	V		34	Rent-Facility & Grounds				6,180	6,180	20	6180
21	V		35	Rent-Equipment & Vehicles				12,907	12,907	21	12907
22	V		36	Other				0		22	
23	V		38	Medically Nec Transportation				0		23	
24	V		39	Ancillary Service Centers				0		24	
25	V		40	Barber and Beauty Shops				0		25	
26	V		41	Coffee and Gift Shops				0		26	
27	V		42	Other				0		27	
28	V									28	
29	V									29	
30	V									30	
31	V									31	
32	V									32	
33	V									33	
34	V									34	
35	V									35	
36	V									36	
37	V									37	
38	V									38	
39	Total				$			$ 24,811	$ * 24,811	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		Sum_6C
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19	Adjustment for Related Organizatio	$ 161,416	Heritage Enterprises, Inc.		$	$ (161,416)	15	-161416
16	V								16	
17	V	10a	Adjustment for Related Organizatior	133,413	Green Tree Pharmacy	100.00%	287,838	154,425	17	154425
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 294,829			$ 287,838	$ * (6,991)	39	

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Print Preview

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Print Page 6D

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

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Print Page 6E

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6E

Print Preview

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Print Page 6F

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6F

Print Preview

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Print Page 6G

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Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6G

Print Preview

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6H

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6H

Print Preview

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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Print Page 6I

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6I

Print Preview

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Facility Name & ID Number HERITAGE MANOR-MOUNT STERI # 0038273 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Boarc	Management	25.98%	27,657	10	0.20	Directors Fe	$ 2,096	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Tre	Management	10.15%	27,657	10	0.20	Directors Fees	2,096	line 18, col 7	2
3	Craig Hart	Secretary/Treasure	Management	20.00%	27,657	10	0.20	Directors Fees	2,096	line 18, col 7	3
	Joe Warner	President	Management	2.50%	9,877	48	0.95	Directors Fees	749	line 18, col 7	
4	Bill Froelich	Chairman of Boarc	Management	25.98%	95,408	10	0.20	Salary	7,230	line 17, col 7	4
5	Tom Jefferson	Asst Secretary/Tre	Management	10.15%	93,858	10	0.20	Salary	7,113	line 17, col 7	5
6	Craig Hart	Secretary/Treasure	Management	20.00%	79,302	10	0.20	Salary	6,010	line 17, col 7	6
7	Joe Warner	President	Management	2.50%	106,779	48	0.95	Salary	8,092	line 17, col 7	7
8	Bob Dickson	Executive Vice Pre	Management	0.80%	58,116	50	1.00	Salary	4,404	line 17, col 7	8
9	Cheryl Lowney	Executive Vice Pre	Management	0.31%	48,824	50	1.00	Salary	3,700	line 17, col 7	9
10	Steve Wannemacher	Executive Vice Pre	Management	0.26%	47,258	50	1.00	Salary	3,581	line 17, col 7	10
11	Connie Hoselton	Sr Vice President	Management	0.17%	32,468	40	1.00	Salary	2,461	line 17, col 7	11
12	Craig Ater	Sr Vice President	Management	0.21%	30,907	50	1.00	Salary	2,342	line 17, col 7	12
13								TOTAL	$ 51,970		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT C [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [xx] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington, Il
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	BEDS	2,328	23	$ 71,961	$ 71,961	87	$ 2,689	1
2	2	Food Purchase	BEDS	2,328	23	0	0	87	0	2
3	3	Housekeeping	BEDS	2,328	23	0	0	87	0	3
4	4	Laundry	BEDS	2,328	23	0	0	87	0	4
5	5	Heat & Other Utilities	BEDS	2,328	23	29,301	0	87	1,095	5
6	6	Maintenance	BEDS	2,328	23	230,824	54,124	87	8,626	6
7	7	Other	BEDS	2,328	23	0	0	87	0	7
8	9	Medical Director	BEDS	2,328	23	0	0	87	0	8
9	10	Nursing & Medical Records	BEDS	2,328	23	0	0	87	0	9
10	11	Activities	BEDS	2,328	23	0	0	87	0	10
11	12	Social Service	BEDS	2,328	23	0	0	87	0	11
12	13	Nurse Aide Training	BEDS	2,328	23	43,025	0	87	1,608	12
13	14	Program Transportation	BEDS	2,328	23	0	0	87	0	13
14	15	Other	BEDS	2,328	23	0	0	87	0	14
15	17	Administrative	BEDS	2,328	23	637,854	637,854	87	23,837	15
16	18	Directors Fees	BEDS	2,328	23	99,885	0	87	3,733	16
17	19	Professional Services	BEDS	2,328	23	244,928	0	87	9,153	17
18	20	Fees, Subscription, Promotion	BEDS	2,328	23	94,145	0	87	3,518	18
19	21	Clerical & General Office Exp	BEDS	2,328	23	3,463,403	3,114,857	87	129,431	19
20	22	Employee Benefits & Payroll	BEDS	2,328	23	491,614	0	87	18,372	20
21	23	Inservice Training & Educati	BEDS	2,328	23	18,866	0	87	705	21
22	24	Travel and Seminar	BEDS	2,328	23	134,093	0	87	5,011	22
23	25	Other Admin. Staff Transpor	BEDS	2,328	23	0	0	87	0	23
24	26	Insurance-Prop.Liab.Malprac	BEDS	2,328	23	35,366	0	87	1,322	24
25	TOTALS					$ 5,595,265	$ 3,878,796		$ 209,100	25

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Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,328	23	$ 0	$ 0	87	$ 0	1
2	30	Depreciation	BEDS	2,328	23	155,150	0	87	5,798	2
3	31	Amortization of Pre-Op & Or	BEDS	2,328	23	0	0	87	0	3
4	32	Interest	BEDS	2,328	23	(1,990)	0	87	(74)	4
5	33	Real Estate Taxes	BEDS	2,328	23	0	0	87	0	5
6	34	Rent-Facility & Grounds	BEDS	2,328	23	165,362	0	87	6,180	6
7	35	Rent-Equipment & Vehicles	BEDS	2,328	23	345,363	0	87	12,907	7
8	36	Other	BEDS	2,328	23	0	0	87	0	8
9	38	Medically Nec Transportation	BEDS	2,328	23	0	0	87	0	9
10	39	Ancillary Service Centers	BEDS	2,328	23	0	0	87	0	10
11	40	Barber and Beauty Shops	BEDS	2,328	23	0	0	87	0	11
12	41	Coffee and Gift Shops	BEDS	2,328	23	0	0	87	0	12
13	42	Other	BEDS	2,328	23	0	0	87	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 663,885	$		$ 24,811	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-MOUNT STERL # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle National Bank		XX	Mortage	16000 plus int	01/15/99	$ 1,073,651	$ 1,034,284	01/15/06	variable	$ 93,316	1
2	LaSalle Loan Amortization		XX	Mortgage							4,208	2
3	Central Office Allocation		XX	Interest Income							(74)	3
4												4
5												5
	Working Capital											
6												6
7											0	7
8												8
9	TOTAL Facility Related						$ 1,073,651	$ 1,034,284			$ 97,450	9
	B. Non-Facility Related*											
10	Interest Income										0	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,073,651	$ 1,034,284			$ 97,450	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	33,674	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	35,128	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,454	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	36,884	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	38,338	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

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IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate ta

To Print this page only

Hold down
Control Key and hit r

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HERITAGE MANOR-MOUNT STERLING COUNTY BROWN

FACILITY IDPH LICENSE NUMBE 0038273

CONTACT PERSON REGARDING THIS REP(CRAIG L. ATER

TELEPHONE (309)823-7135 FAX #:( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	0519400100	HERITAGE MANOR-MOUN	$ 35,128	$ 35,128
2.		HERITAGE MANOR-MOUN	$ 0	$ 0
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,128	$ 35,128

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES xx NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Numb HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1979	$ 8,000	1
2	Nursing Home				2
3	TOTALS			$ 8,000	3

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Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87				$ 914,680	$		$	$	$	4
5					0						5
6											6
7											7
8											8
	Improvement Type**										
9	1987 Improvements			1987	17,047						9
10	1987 Improvements			1987	73,700						10
11	1988 Improvements			1988	25,324						11
12	1989 Improvements			1989	64,856						12
13	1990 Improvements			1990	14,699						13
14	1991 Improvements			1991	18,519						14
15	1992 Improvements			1992	18,102						15
16	1993 Improvements			1993	54,992						16
17	1994 Improvements			1994	114,380						17
18	1995 Improvements			1995	22,646						18
19	Fire Alarm System			1996	27,410						19
20	Electrical Wire--Resident Rooms			1996	2,675						20
21	Drainage System			1996	5,100						21
22	Code Alert			1996	6,916						22
23	Resident Room Remodel			1996	26,925						23
24	Physical Therapy Room Remodel			1996	6,725						24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							5,798	5,798		34
35	Book Depreciation					64,416		58,575	(5,841)	593,010	35
36					1,414,696						36

*Total beds on this schedule must agree with page 2. See Page 12A, Line 70 for Total

**Improvement type must be detailed in order for the cost report to be considered complete.

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0 Page 12D
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0 Page 12F
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STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Shower/Remodel	1997	6,033						37
38	Air Conditioner	1997	1,365						38
39	Resident Room Remodel	1997	199,404						39
40									40
41	Garbage Disposal	1998	797						41
42									42
43	Gerator Repair	1999	5,712						43
44	Kitchen Air Conditioner	1999	1,450						44
45									45
46	Door Monitor System	2000	5,196						46
47	Water Heater	2000	3,995						47
48	Sink Installation & Faucet	2000	1,736						48
49									49
50	Water Main Repair	2001	2,308						50
51	Water Heater	2001	3,016						51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 231,012	$ 64,416		$ 64,373	$ (43)	$ 593,010	70

**Improvement type must be detailed in order for the cost report to be considered complete.

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STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 231,012	$ 0		$ 0	$	$ 593,010	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 231,012	$ 0		$ 0	$ 0	$ 593,010	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number: HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 231,012	$ 0		$ 0	$	$ 593,010	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 231,012	$ 0		$ 0	$ 0	$ 593,010	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 231,012	$ 0		$ 0	$	$ 593,010	1
2									2
3									3
4									4
5									5
6									6
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 231,012	$ 0		$ 0	$ 0	$ 593,010	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Numbe HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 231,012	$ 0		$ 0	$	$ 593,010	1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 231,012	$ 0		$ 0	$ 0	$ 593,010	34

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Numbe HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 231,012	$ 0		$ 0	$	$ 593,010	1
2									2
3									3
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6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 231,012	$ 0		$ 0	$ 0	$ 593,010	34

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 479,760	$ 45,403	$ 49,475	$ 4,072		$ 397,941	71
72	Current Year Purchases	15,159						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 494,919	$ 45,403	$ 49,475	$ 4,072		$ 397,941	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,148,627	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 109,819	82
83	Straight Line Depreciation	(line 70, col.7 + line 75 ,col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 113,848	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,029	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 990,951	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ 14,164 Description: Copier, Cell Phone and Central Office Allocation
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ___

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		1,085		1,085
3	Classroom Wages (a)		853		853
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,938	$	$ 1,938
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,938			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$		$ 8,478	$		$ 8,478	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			4,665			4,665	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			21,330	0		21,330	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				289,189		289,189	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39/3				9,197			9,197	13
14	TOTAL			$		$ 43,670	$ 289,189		$ 332,859	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

pt adj -4234
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Ot adj -818

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Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,459	$	1
2	Cash-Patient Deposits	10,773		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	360,386		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,351		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(80,612)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 317,357	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	125,400		13
14	Buildings, at Historical Cost	1,759,627		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	428,342		16
17	Accumulated Depreciation (book methods)	(988,364)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	18,747		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,343,752	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,661,109	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 41,349	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,773		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	133,149		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,852		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,884		32
33	Accrued Interest Payable	3,577		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 228,584	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,034,284		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,034,284	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,262,868	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 398,241	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,661,109	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number HERITAGE MANOR-MOUNT STERLING # 0038273 Report Period Beginning 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 144,346	1
2	Restatements (describe):		2
3	audit Adjustment	0	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 144,346	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	253,895	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 253,895	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 398,241	24 *

*** This must agree with page 17, line 47.**

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